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ABSTRACT

The number and complexity of health issues facing today's adolescents defy reason. Traditional health/sex education programs and those facilitating parent-adolescent communication are inadequate. Information alone, without access to a range of medical services, cannot prevent pregnancy among sexually active adolescents, help already pregnant young women, provide support for students facing ready access to illicit drugs, or help youth understand the importance of proper nutrition. A link between the schools and medical providers seems an optimal solution. More than 70 U.S. schools have established health clinics to meet adolescents' special health needs. Since 1983, school-based clinics have been established in the Kansas City (Missouri) School District. This paper describes a project to evaluate these clinics' effectiveness and to monitor student health and life habits in area high schools with and without clinics. Between 1982 and 1987, 4,410 students were surveyed regarding their health and living habits, homelife characteristics, and future plans, using the High School Health Questionnaire. The students attended one of four high schools, three of which had school-based health clinics. In general, the clinics had successfully carried out their program objectives. Implications for improving health clinic evaluations are also discussed. Included are 11 tables and three references. (MLH)

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Health Habits of Urban High School Students: Evaluation of School-Based Clinics

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Abstract

This paper reports the results of surveys of 4,410 high school students conducted between 1982 and 1987 concerning their health and living habits, homelife characteristics, and future plans. The students attended one of four high schools, three of which had school-based health clinics. The project was designed to evaluate the effectiveness of those clinics and to monitor the health and life habits of the students, both those who had used the clinics and those who had not. In general, the clinics had successfully carried out the objectives for which they were designed. Survey results are also discussed in light of their implications for improvements in evaluation of school-based health clinic arrangements of this type.

The number and complexity of health issues facing adolescents today defies reason; for example the endless variety of available drugs, AIDS and other sexually transmitted diseases, decisions regarding sexual activity, contraception, pregnancy . . .; the list could go on and on. The traditional approach to dealing with these and related issues has been health/sex education programs, generally directed at students. More progressive programs of this type have also involved parents in attempts to facilitate parent-adolescent communication and train parents to be the primary health/sex educators of their children (Children's Defense Fund, 1986).

It is clear, however, that information alone, without access to a range of medical services including counseling, routine examinations, contraception, and prenatal care, cannot prevent pregnancy among sexually active adolescents, help an already pregnant adolescent, provide support for students facing ready access to the range of illicit drugs, or assist adolescents in understanding the importance of proper nutrition. Thus, a link between the schools and medical providers would seem to be an optimum solution.

Currently, the most widely discussed approach to the provision of routine medical services to students is the school-based clinic. More than 70 schools around the country now have health clinics that were started in order to meet the special health needs of adolescents, particularly low-income adolescents. Among the services most frequently provided at these clinics are athletic physicals, general health assessments, screening services, immunization, first-aid care, family planning, prenatal care, drug and alcohol abuse programs, and nutrition and weight reduction programs. These clinics differ from traditional school health programs in that they prescribe and sometimes dispense medication (Kenney, 1987).

Since 1983, school-based clinics of this type have been established in three senior high schools in the Kansas City, Missouri school district. The clinics were established in or near areas with medically underserved populations with three major objectives in mind: (1) to provide early detection and treatment of conditions and illnesses; (2) to motivate teenagers to adopt healthy lifestyles and discard risk-taking behaviors; and (3) to teach adolescents how to use the health care system appropriately and effectively. It should be noted here that the clinics are not designed to be preventative in nature, but rather to provide the diagnostic, lifestyle, and educational services outlined above.

Services provided at the clinics are analogous to those offered by a private-sector family practice physician, and include diagnosis and treatment of common complaints, family planning and routine obstetrical-gynecological services, physical examinations, prenatal care and mental health services. While the scope of services is comparable to that provided in traditional health care settings, the clinics are oriented toward diagnosis and education, to the end that teenagers develop behavior patterns that contribute to adult productivity and reduction in chronic disease.

Young people using the clinic are afforded the same confidentiality that applies to traditional patient-physician relationships. To receive clinic services, however, teenagers are required to present, on an annual basis, a general consent form signed by parents or guardians.

The clinic team typically consists of: a full-time nurse practitioner; a part-time social worker; a full-time medical assistant; a pediatric physician(s) at least eight hours per week; and an obstetrical-gynecological physician(s) at least two hours per week.

The present project was designed to evaluate the effectiveness of those clinics and monitor the health and life habits of students in those high schools as well as in other high schools where clinics had not been established. To that end, students in two of the "clinic" high schools were surveyed shortly after and approximately three to four years after initiation of clinic services. In addition, students in the third "clinic" high school and in one "non-clinic" high school were also surveyed to serve as informal comparison groups.

Method

Subjects

Over a six-year period (1982-1987), 4,410 senior high school students, 9th through 12th grades, in a major midwestern metropolitan area were surveyed regarding their health and living habits, homelife characteristics, and future plans. Surveys were administered on a predetermined day in all social studies classes, which enroll between 90 percent and 98 percent of all the students in the respective high schools. Students in High School A were surveyed in 1982 shortly after the initiation of clinic services and again in 1985. Similarly, students in High School B were surveyed in 1983 and again in 1987. Students in High Schools C and D were surveyed in 1986 and 1987 respectively.

Materials

The High School Health Questionnaire was constructed after interviewing high school administrators and faculty in the district, and the staff of a planned health clinic at High School A about major areas of health-related concerns.

An initial draft of the survey was designed using items for which national comparative data were available; however, after pilot-testing the

survey, it was determined to be too long and at too high a reading level for use in the intended setting. A revised instrument that took between 20 and 30 minutes for students to complete was subsequently developed and administered in its same general form for the entire project. As the project progressed, several items were added to keep up with new developments in adolescent health habits. For example, in 1987 an item was added regarding use of "crack."

Procedure

As noted above, surveys were administered in all social studies classes in each school on a predetermined day. In an attempt to obtain more complete sets of responses, two make-up sessions were held at each high school for students who did not complete the survey on the day of its administration. The procedures produced "coverage" ranging from roughly 50% to 82% of the students in the respective high schools.

Survey responses were analyzed using descriptive statistical techniques for group data including frequency distributions and crosstabulation. In addition, appropriate correlational procedures were utilized to determine relationships betwen health habits and clinic use.

Results and Discussion

Enrollment, response rates and selected student characteristics are displayed in Table 1. As can be seen in Table 1, response rates ranged from

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Insert Table 1 about here

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slightly under 50% (48.3% in high school D and 49.8% in high school A in 1982) to over 80% (82.2% in high school B in 1983). For all six administrations of the survey a total of 4,410 usable responses were received out of 6,205 total enrollments, an overall response rate of 71.1%.

The response rates of the surveys did not guarantee that the surveys' results were representative of all high school students in the targeted schools. In fact, nonrespondents were likely to be different in important, but unknown, ways from respondents. Specifically, because respondents were present on the day of the administration of the survey, they may have been healthier than nonrespondents. Similarly, respondents may have been better students; less likely to cut class; more responsible, cooperative, and respectful of authority--all characteristics positively related to health. Thus, respondents probably represented a somewhat healthier profile than all targeted high school students, and the results of the surveys were limited in their generalizability to the population of concern.

Overall, examination of the demographic characteristics reveals that the schools were roughly comparable. There was generally a slight majority of female students. Also, age and grade distributions were roughly equivalent across all six survey administrations (see Table 1).

Some notable chronological trends are apparent in Table 2 which contains data regarding respondents' family and living arrangements. The proportion of

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Insert Table 2 about here

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married students seemed to decrease since the early surveys. Similarly, fewer students were living with both parents, although the proportion living with one parent remained relatively stable. "Other" household arrangements, such as living with grandparents, aunts and uncles, and siblings increased. Household size also seemed to diminish, with the proportion of one or two person households increasing by a factor of roughly 1.5 to 3.0 accompanied by a corresponding reduction in households of six or more.

Finally, in line with national trends, the survey results document an increasing tendency for high school students to work in jobs outside the home. As can be seen in Table 1, there was a steady increase in students working both less than 30 hours per week and more than 30 hours per week across the six surveys.

Table 3 documents clinic activity in those three high schools with clinics (A, B, & C). Since initiation of the first clinic in late 1982 there

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Insert Table 3 about here

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have been over 62,000 separate clinic visits, approximately half medical and half non-medical in nature. Overall, approximately one-third of clinic diagnoses dealt with emotional/psychological issues, a pattern which was prevalent in two of the three schools. Routine medical problems accounted for about one-fourth of the total diagnoses followed by contraceptive management (18.2%) and prenatal care (13.2%). Again, similar patterns generally appeared in each of the individual schools.

Table 4 provides comparisons of general health habits of respondents in the two clinic schools in which the clinics had been in operation for several years. As is apparent from the table, self- perception of general health and

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Insert Table 4 about here

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self-reported days missed due to illness were relatively stable in both schools. Visits to a dentist within the year prior to the survey had increased appreciably in School A between 1982 and 1986 and slightly in School B between 1983 and 1987. Likewise, visits to a physician had increased in

school B but declined slightly in School A. Finally, the percentage of respondents who indicated that they had a personal physician was noticeably higher at the time of the second survey for High School A and slightly so for High School B. Thus, it would seem that the clinics may have been at least partially successful in educating students about and introducing them into the health care system.

Table 5 illustrates self-reported use of drugs and alcohol, again in Schools A and B across two survey administrations. As noted on the table,

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Insert Table 5 about here

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percentages refer to the proportion of respondents who reported that they never or hardly ever used the substance in question. As can be seen in the table, self-reported use of all these substances was quite low, with large, impressive majorities of students reporting that they were not involved with drugs and alcohol. In fact, fewer than 5% of respondents in either school reported more than very infrequent use of substances such as amphetamines, hallucinogens, heroin, or cocaine. The table also points to decreased use of marijuana/hashish and cigarettes across the two survey periods in both schools. Use of alcohol decreased slightly in School A but increased in School B, a finding that was paralleled by self-reported days of school missed due to drug/alcohol use.

Table 6 represents the third set of comparisons across survey administrations in clinic Schools A and B, in this case dealing with

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Insert Table 6 about here

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self-reported sexual activity and use of birth control. There is no indication that the presence of a clinic has any effect on sexual activity. In general, levels of sexual activity, both in terms of frequency of intercourse in general and within the thirty days prior to the survey, was remarkably stable in both schools.

Of significant interest is the lack of any indication that clinics lead to increased sexual activity. Thus, the contention of critics of family planning agencies and school clinics that provision of contraceptive management and information promotes and/or facilitates increases in sexual activity is certainly not borne out by these data.

There is no indication that the presence of a clinic induces adolescents to participate in contraceptive management and family planning activities prior to becoming sexually active. Nor do the clinics appear to have any effect on initiation or level of sexual activity among students. What the clinics do seem to be associated with, however, is more responsible sexual activity on the part of students who choose to avail themselves of the services provided by the clinics, based on the increased use of birth control in both schools across survey administrations.

While the three previous tables (3, 4, and 5) concentrated on comparisons of two clinic schools across time, the next two tables (7 and 8) provide summary data which compare clinic users and non-users in those two schools (A and B) at the time of the second survey administration (1985 and 1987, respectively). Relationships between the various variables and clinic use/non-use were evaluated using the Kendall's Tau rank order correlation coefficient procedure. Generally, significant relationships were observed between clinic use and responsible health practices and sexual activities, although these relationships were more prevalent in School A.

For example, Table 7 displays data pertaining to selected health habits. As is apparent, clinic users in School A were more likely to report

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Insert Table 7 about here

"excellent" current health than non-users, but not in School B. Similarly, clinic users in School A were more likely than non-users to report having seen a dentist within the year prior to the survey although, again, this was not the case for School B. Clinic users in both schools, however, were more likely to have seen a doctor within the year prior to the survey than were non-users.

Interestingly, there were significant relationships between clinic use and the use of both alcohol and marijuana/hashish in School B. That is, use of these substances was more prevalent among clinic users than non-users. It would appear that the clinic is at least partially successful in reaching an important target population, drug users. Similar, although smaller and nonsignificant, relationships were observed for School A.

Findings regarding sexual activity, shown in Table 8, indicated that, in School A, the clinic attracted students who were more sexually active than those students who did not use clinic services. While the same relationships were observed for school B, they were not statistically significant. While this result might seem to imply a causal connection between clinic use and sexual activity, the lack of increase in overall sexual activity in both schools across time (cf. Table 5) strongly suggests that this was not the case.

More importantly, there were significant relationships between clinic use and use of birth control in both schools. In School A, 55.1% of clinic users

reported using birth control all or some of the time while only 34.9% of non-users did so. Similar figures for clinic users and non-users in School B were 43.3% and 28.9%, respectively. These figures reinforce, once again, the conclusion that clinic presence (and, necessarily, use) is associated with responsible sexual behavior on the part of adolescents.

The final three tables (9, 10, and 11) provide comparison data from a clinic school (B) and a non-clinic school (D) at roughly the same point in time, 1987. Table 9 details the general health habits of respondents in the two schools. Responses were generally comparable for both schools. A

Insert Table 9 about here

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somewhat greater proportion of students in School D (non-clinic) reported excellent health (46.0%) than in School B (clinic, 42.7%) Similar results were obtained for students who had seen a physician within the year prior to the survey. Conversely, students in School D reported missing more days of school due to illness in the four weeks prior to the survey than those in School B. Similarly, a greater percentage of respondents in School B reported having a personal physician than in School D.

Comparative use of drugs and alcohol in the two schools is outlined in Table 10. Use of alcohol, marijuana/hashish, heroin, cocaine, and cigarettes

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Insert Table 10 about here

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were all slightly more prevalent in the clinic school (B) than in the non-clinic school (D). In addition, a larger proportion of students in School B reported having missed school due to drug/alcohol use in the year prior to the

survey than in School D. These findings, are not surprising since the clinics were not designed to be preventative in nature. In addition, it is clear that the student population at School B was an appropriate target population for clinic services.

Finally, Table 11 reports comparative sexual activity and use of birth control in the two schools. Incidence of sexual activity is virtually

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Insert Table 11 about here

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identical in both schools. However, School B shows slightly higher use of birth control (49.4% all or some of the time) than School D (47.3%), a somewhat lower pregnancy rate (9.3% versus 11.0%, respectively), and a lower rate of males reporting having impregnated a partner (7.2% versus 11.7% respectively). Once again, the data point to the importance of the clinic in its relation to responsible adolescent sexual behavior.

Conclusions

It is clear from the data presented here that the school-based clinics in the Kansas City, Missouri school district are, at least in part, meeting the objectives for which they were designed and implemented. The clinics have served thousands of students, providing early diagnosis and treatment of a variety of conditions, many of which would have undoubtedly gone undetected and untreated. Generally, students in clinic schools, particularly clinic users, have adopted more healthier habits and lifestyles, and conversely shown less inclination to participate in activities which might be associated with some personal risk. And, finally, students in clinic schools have learned to more appropriately and effectively take advantage of the health care system at large.

This is not to say, of course, that the clinics are a panacea, a "be-all and end-all" for medically underserved areas and populations. The clinics are designed to provide treatment, rather than prevention. Indeed, it is in this area that one of their major successes lies. Neither are the clinics uniformly successful, as may be seen in the data here. Degree of success depends on a multitude of variables such as the care and detail involved in appropriate needs assessments and planning, the characteristics of the student population, the school faculty and staff, and the clinic personnel themselves. All these variables interact with many others to determine the success of this type of endeavor.

Finally, and by no means least important, are the innumerable problems, methodological and otherwise, encountered in attempts to evaluate school-based clinics. Brandis (1987) has discussed this in some detail and recognized such issues as dealing with school boards and district administrators, gaining access to student populations, shaping policies regarding passive versus active parental permission, and coping with the transient nature of student populations, particularly those in medically underserved areas. In addition, specific methodological problems include types of evaluation measures employed (outcome and otherwise), difficulties in collecting data (particularly in terms of response rates), and choice of and problems with data analysis techniques.

The present clinic arrangement and the accompanying evaluation effort reported here suffer, to some degree, from all these shortcomings. In particular, additional efforts need to be made to increase the rigor of the evaluation methodology. Further, additional control/comparison data need to be obtained and more detailed and appropriate statistical analyses need to be utilized.

In spite of these caveats, however, available data and results of extant evaluation efforts clearly demonstrate the efficacy and success ~~of~~ the clinics themselves.

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Table 1

Enrollment, Response Rates, and Student Characteristics

	School					
	A	A	B	B	C	C
	1982	1985	1983	1987	1986	1987
Total Enrollment:	1050	980	1485	1200	1400	900
Survey Responses:						
number	523	589	1220	792	851	435
percent	49.8	60.1	82.2	66.0	60.8	48.3
Student Characteristics:						
Sex						
male	43.8%	42.6%	47.7%	43.6%	51.5%	46.2%
female	54.7	53.3	52.1	55.8	47.7	52.2
unknown	1.5	4.1	.3	.6	.8	1.6
Age						
14 and under	10.9%	9.8%	24.0%	10.8%	15.1%	9.1%
15	25.2	31.6	23.0	28.7	25.9	36.3
16	30.2	23.1	27.0	34.0	27.2	30.0
17	21.0	23.1	20.4	19.4	20.5	19.2
18 and over	12.7	12.4	4.8	9.1	11.3	5.1
Grade						
9	27.9%	29.4%	29.3%	31.6%	31.4%	37.0%
10	22.8	27.3	23.6	30.3	24.9	28.7
11	23.3	22.9	25.6	27.1	22.7	23.7
12	20.5	16.1	21.1	10.0	20.4	9.0
unknown	5.5	4.2	.4	1.0	.6	1.6

Table 2

Family and Living Arrangements

	School					
	A	A	B	B	C	D
	1982	1985	1983	1987	1986	1987
Marital Status:						
single	84.9%	85.2%	85.1%	86.6%	88.2%	87.4%
engaged	6.7	5.8	8.5	7.7	5.0	7.8
married	1.7	1.9	1.4	1.6	.9	.5
unknown	6.7	7.1	4.8	4.0	5.8	4.4
Household Makeup:						
live with both parents	41.5%	42.7%	38.2%	33.8%	37.5%	25.8%
live with one parent	42.7	38.7	45.1	43.2	42.7	42.9
other	15.8	18.6	16.7	23.0	19.8	31.3
Number in Household:						
1-2	2.7%	3.4%	6.4%	8.5%	8.0%	8.9%
3-5	57.3	61.3	63.3	63.8	62.9	55.7
6 or more	40.0	35.3	30.3	27.7	29.1	35.4
Job Outside Home:						
no	80.5%	65.7%	76.9%	62.0%	67.6%	64.8%
yes, 30 hours/ week or less	12.0	21.6	15.9	21.1	21.2	21.1
yes, More than 30 hours/week	7.5	12.7	7.2	16.9	11.2	14.1

Table 3

Clinic Activity

	School			
	A	B	C	
Activity	1982-1987	1983-1987	1985-1987	All
Student Visits:				
medical	12,158	13,612	6,294	32,064(51.5%)
non-medical	13,833	11,394	4,961	30,188(48.5%)
total	25,991	25,006	11,255	62,252
Diagnosis:				
emotional/ psychological	1985(35.7%)	1053(30.7%)	183(22.3%)	3221(32.8%)
routine medical	1160(20.9%)	963(28.0%)	231(28.1%)	2354(24.0%)
contraceptive management	905(16.3%)	689(20.0%)	196(23.9%)	1790(18.2%)
prenatal care	750(13.5%)	513(14.9%)	33 (4.0%)	1296(13.2%)
sprains/ contusions	288 (5.2%)	128 (3.7%)	50 (6.1%)	466 (4.7%)
other	470 (8.5%)	89 (2.6%)	128(15.6%)	687 (7.0%)
total	5558	3435	821	9814

Note: Percents are column percents and may not total 100% due to rounding.

Table 4

General Health Habits: Comparisons in Clinic Schools

	School A		School B	
Item	1982	1985	1983	1987
General Health:				
excellent	45.5%	42.6%	45.7%	42.7%
good	41.4	43.1	41.1	40.8
fair	10.9	13.6	12.3	14.6
poor	2.1	.7	.7	1.9
Days Missed Due To Illness: [1]				
zero	62.7%	66.6%	61.3%	60.3%
1-2	20.9	18.0	22.1	19.3
3-5	10.9	11.0	11.9	12.5
6 or more	5.6	4.4	4.9	6.4
Last Visit to Dentist:				
within past year	46.9%	53.4%	52.7%	54.5%
1-2 years ago	14.8	15.3	14.1	10.6
more than 2 years ago/don't remember	38.2	31.3	33.3	34.8
Last Visit to Doctor:				
within past year	59.6%	56.6%	61.8%	65.1%
1-2 years ago	10.2	12.1	13.3	10.1
more than 2 years ago/don't remember	30.2	25.3	25.0	24.8
Have Own Personal Doctor:	57.6%	64.5%	64.0%	66.6%

Note 1: Within four weeks preceding survey.

Table 5

Selected Drugs and Alcohol: Comparisons in Clinic Schools[1]

	School A		School B	
	1982	1985	1983	1987
Alcohol	77.9%	78.5%	78.8%	72.5%
Marijuana/Hashish	77.1	86.5	79.5	84.7
Amphetamines	96.0	95.5	96.1	97.4
Hallucinogens	97.7	96.1	99.1	97.4
Heroin	97.6	96.6	99.1	96.7
Cocaine	95.6	96.2	96.7	96.4
Cigarettes	87.0	94.7	88.3	93.3
Missed School Due to Drug/Alcohol Use[2]	6.5%	4.9%	5.7%	6.2%

Notes: 1. Percentages refer to the proportion of respondents who reported that they never or hardly ever used the substance in question.

2. Missed school due to drug/alcohol use in the year preceding the survey.

Table 6

Sexual Activity and Use of Birth Control: Comparisons in Clinic Schools

Activity	School A		School B	
	1982	1985	1983	1987
Had Sexual Intercourse:				
no	31.8%	29.5%	29.1%	28.6%
once or twice	15.6	16.9	16.1	15.4
three to five times	9.2	10.5	11.0	10.6
more than five times	43.5	43.1	43.8	45.4
Had Sexual Intercourse in Past 30 Days:				
no	51.8%	50.5%	51.7%	52.8%
once or twice	22.5	22.9	25.7	22.7
three to five times	10.3	12.1	11.8	10.8
more than five times	15.4	14.5	10.8	13.7
Used Birth Control:				
all of the time	23.9%	30.9%	27.0%	33.0%
some of the time	12.8	14.9	14.9	16.4
never	49.4	37.1	40.6	35.1
not sure	13.9	17.1	17.5	15.4
Type of Birth Control:				
pill	42.1%	38.1%	38.7%	31.4%
rhythm	3.8	6.5	6.9	4.9
condom	36.6	37.1	43.1	43.8
withdrawal	7.2	10.7	4.4	14.7
foams/jels	.4	1.0	1.4	.4
others	9.8	6.5	5.6	4.9
Ever Been Pregnant (females only)	11.4%	10.7%	11.0%	9.3%
Ever Had a Baby (females only)	7.9%	5.8%	5.0%	4.9%
Got a Girl Pregnant (males only)	16.0%	21.6%	15.0%	7.2%

Table 7

Selected Responses for Clinic Users Versus Clinic Non-Users in Clinic Schools[1]

Item	School A(1985) Clinic Users	School A(1985) Clinic Non-Users	School B(1987) Clinic Users	School B(1987) Clinic Non-Users
Current Health:				
excellent	45.4%[2]	39.2%	41.4%	43.3%
good	42.3	44.6	44.5	38.1
fair	11.6	15.4	13.5	15.8
poor	.7	.8	.6	2.8
Last Visit to Doctor:				
within past year	61.1%[2]	52.0%	69.7%[2]	61.5%
1-2 years ago	11.1	13.0	9.4	10.3
more than 2 years ago/don't remember	27.9	34.9	21.0	28.2
Last Visit to Dentist:				
within past year	59.2%[2]	47.6%	54.0%	55.2%
1-2 years ago	12.7	18.1	11.3	10.0
more than 2 years ago/don't remember	28.0	34.4	34.7	34.8
Never/Rarely Use Drugs:[3]				
alcohol	76.7%	80.4%	65.9%[2]	76.9
marijuana/hashish	85.1	87.9	80.4[2]	87.5
cocaine	96.9	95.2	96.5	96.6

Notes: 1. Significant relationships between activities and clinic use/non-use in this table were determined using Kendall's Tau rank order correlation coefficient procedures.

2. $p < .05$

3. Percentages refer to proportion of respondents who reported that they never or hardly ever used the substance in question.

Table 8

Sexual Activity and Use of Birth Control for Clinic Users Versus Clinic Non-Users in Clinic Schools[1]

Activity	School A(1985) Clinic Users	School A(1985) Clinic Non-Users	School B(1987) Clinic Users	School B(1987) Clinic Non-Users
Had Sexual Intercourse:				
no	25.0%[2]	34.5%	21.6%	33.9%
once or twice	14.9	19.5	12.9	17.2
three to five times	10.4	10.7	8.8	11.6
more than five times	49.7	35.2	56.7	37.4
Had Sexual Intercourse Past 30 Days:				
no	47.4%[2]	53.6%	45.1%	58.5%
once or twice	21.6	24.3	22.4	21.6
three to five times	15.8	8.4	13.5	9.3
more than five times	15.1	13.7	18.5	10.7
Used Birth Control:				
all of the time	38.4%[2]	21.9%	28.3%[2]	20.3%
some of the time	16.7	13.0	15.8	8.6
never	34.5	47.3	20.7	28.4
not sure	10.3	24.9	12.5	9.3

Notes: 1. Significant relationships between activities and clinic use/non-use in this table were determined using Kendall's Tau rank order correlation coefficient procedures.

2. $p < .05$

Table 9

General Health Habits: 1987 Comparison of a Clinic Versus a Non-Clinic School

Item	School B (Clinic)	School D (Non-Clinic)
General Health:		
excellent	42.7%	46.0%
good	40.8	41.2
fair	14.6	10.7
poor	1.9	2.1
Days Missed Due to Illness:[1]		
zero	60.3%	59.0%
1-2	19.3	17.5
3-5	12.5	14.4
6 or more	6.4	8.7
Last Visit to Dentist:		
within past year	54.5%	52.6%
1-2 years ago	10.6	13.2
more than 2 years ago/ don't remember	34.8	34.1
Last Visit to Doctor:		
within past year	65.1%	70.6%
1-2 years ago	10.1	8.0
more than 2 years ago/ don't remember	24.8	21.5
Have Own Personal Doctor:	66.6%	60.2%

Note 1: Days missed due to illness in four weeks preceding survey.

Table 10

Selected Drugs and Alcohol: 1987 Comparison of a Clinic Versus a Non-Clinic School[1]

	School	
	B (Clinic)	D (Non-Clinic)
Alcohol	72.5%	77.1%
Marijuana/Hashish	84.7	87.8
Amphetamines	97.4	97.5
Hallucinogens	97.4	98.5
Heroin	96.7	99.3
Cocaine	96.4	98.5
Cigarettes	93.3	95.2
Missed School Due to Drug/Alcohol Use[2]	6.2%	3.5%

Note: 1. Percentages refer to the proportion of respondents who reported that they never or hardly ever used the substance in questions.

2. Missed school due to drug/alcohol use in the year prior to the survey.

Table 11

Sexual Activity and Use of Birth Control: 1987 Comparisons of a Clinic Versus a Non-Clinic School

Activity	School B (Clinic)	School D (Non-Clinic)
Had Sexual Intercourse:		
no	28.6%	28.9%
once or twice	15.4	14.3
three to five times	10.6	11.8
more than five times	45.4	45.0
Had Sexual Intercourse in Past 30 Days:		
no	52.8%	51.3%
once or twice	22.7	25.6
three to five times	10.8	12.7
more than five times	13.7	10.4
Used Birth Control:		
all of the time	33.0%	35.2%
some of the time	16.4	12.1
never	35.1	35.3
not sure	15.4	17.3
Type of Birth Control:		
pill	31.4%	28.3%
rhythm	4.9	1.7
condom	43.8	45.5
withdrawal	14.7	17.2
foam/jels	.4	1.3
others	4.9	6.0
Ever Been Pregnant (females only)	9.3%	11.0%
Ever Had a Baby (females only)	4.9%	4.8%
Got a Girl Pregnant (males only)	7.2%	11.7%